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SENATE BILL 1767
By Cooper

AN ACT to amend Tennessee Code Annotated, Title 56; Title 63, Chapters 3, 5, 6, 8, 9, and 10, and Title 68, Chapter 11, to enact the Patient Advocacy Act of 1997.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. This act shall be known as the Patient Advocacy Act of 1997 and shall be codified as a new chapter in Tennessee Code Annotated, Title 56.

SECTION 2. As used in this act:

(1) “Copayment” means a type of cost-sharing whereby a beneficiary of a health benefits plan is required to pay a specified predetermined amount of money per unit of service or a percentage of the charge for the health care services provided by a health care provider. The copayment is payable at the time the health care services are rendered. The copayment may be a fixed or a variable amount.

(2) “Credentials” or “credentialing” means an insurer’s authorization to a health care provider to provide covered health care services to the beneficiaries of a health benefits plan administered by that insurer.

(3) “Gatekeeper system” means a system of administration used by a health benefits plan in which a primary care provider furnishes basic patient care and coordinates diagnostic testing, indicated treatment, and specialty referral for the beneficiaries of a health benefits plan.

(4) “Health benefits plan” means any public or private health plan, program, policy, subscriber agreement, or contract (whether a comprehensive plan where all services are provided or a combination of separate plans where services are provided) implemented in the state of Tennessee which includes or may include payment, reimbursement (including capitation) or financial compensation for the provision of health care services to beneficiaries of that plan, but does not include workers’ compensation coverage or reimbursement or policies.

(5) “Health care provider” means any podiatrist, dentist, physician, optometrist, osteopathic physician, or pharmacist licensed under Tennessee Code Annotated, Title 63, Chapters 3, 5, 6, 8, 9 or 10, and any hospital or ambulatory surgical treatment center licensed under Tennessee Code Annotated, Title 68, Chapter 11.

(6) “Health care services” means any services or products included in the furnishing to any person of medical care or hospitalization, or incidental to the furnishing of such care or hospitalization, as well as the furnishing to any person of any other services or products for the purpose of preventing, alleviating, curing, or healing human illness, injury, or disability.

(7) “Insurer” means a licensed insurance company, health maintenance organization, managed care contractor, or any other legal entity that operates a health benefits plan regulated under Title 56, Chapters 7, 19, 25, 26, 27, 28, 29, 30, 31, or 32.

SECTION 3. All insurers shall disclose to all prospective and currently enrolled beneficiaries of a health benefits plan written information about the terms and conditions of the health benefits plan so that such prospective and current beneficiaries can make informed decisions about joining or continuing in a certain health benefits plan. All written plan descriptions shall be in a readable and understandable format, consistent with the standards developed for supplemental insurance coverage under Title XVIII of the Social Security Act. Specific items that must be included in the written description are:

(1) Coverage, provisions, benefits, and any exclusions by category of service or health care provider and, if applicable, by specific service;

(2) An up-to-date listing of all health care providers credentialed to provide health care services to the beneficiaries of a health benefits plan. A complete list of providers shall be prepared at least annually, and a supplemental list of recently credentialed providers and providers who are no longer credentialed shall be prepared at least semi-annually;

(3) Any and all prior authorization or other review requirements, including gatekeeper requirements, specialist referral rules, preauthorization review, concurrent review, post-service review, post-payment review, and any procedures that may lead a beneficiary to be denied coverage for, or not be provided, a particular service;

(4) Financial arrangements or contractual provisions, including capitation, with hospitals, review companies, physicians, and any other providers of health care services that would limit the services offered, restrict referral or treatment options, or negatively affect the health care provider's fiduciary responsibility to his or her patients, including but not limited to financial incentives not to provide medical or other services;

(5) An explanation of how any plan limitations affect beneficiaries, including information on the financial responsibility or beneficiaries for payment or copayments or other non-covered or out-of-plan services;

(6) Whether and to what extent there are drug formulary limitations, including which drugs are subject to prior authorization approval or showings of medical necessity, whether there are exceptions allowed to the standard formulary list, whether generic drug substitutions are required, and a detailed explanation of the steps necessary to gain such authorization or exception to the standard formulary list;

(7) Any limitations on the choice of primary care physicians, access to specialists, and the method of reimbursement of health care providers;

(8) Whether and to what extent the medical records of, and other personal information about, beneficiaries will be shared with or sold to any other entity;

(9) The claims filing deadlines and whether there are exceptions for situations beyond the control of health care providers and beneficiaries;

(10) The maximum length of time the insurer will take in responding to requests by health care providers or beneficiaries for prior authorization of services, whether that decision covers medical necessities or determinations about the certification of continued length of stay; and

(11) A listing of treatments the insurer deems experimental and the basis for such determinations.

SECTION 4. If an insurer expressly covers certain health care services which may be performed by or at a health care provider as defined in this act, then any licensed health care provider desiring to provide those health care services to the beneficiaries of a particular health benefits plan shall follow the procedures set forth in this act.

SECTION 5.

(a) Any health care provider within the geographic service area of a health benefits plan may apply to the insurer which administers that health benefits plan to be credentialed to provide covered health care services to the beneficiaries of that health benefits plan.

(b) Except for the reasons set forth in subsection (c), an insurer shall not fail or refuse to credential a health care provider who applies for credentials and who states in writing that he, she or it will accept the health benefit plan's operating terms and conditions, schedule of fees and expenses, utilization regulations, and quality standards. An insurer shall not require that a health care provider hold hospital staff privileges in order to obtain credentials to provide non-hospital-based services covered under that plan.

(c) If an insurer makes a written determination that a health care provider has a history of unprofessional conduct or a pattern of malpractice, the insurer may refuse to credential that provider.

(d) An insurer shall not impose, directly or indirectly, any monetary advantage or penalty under a health benefits plan that would affect a beneficiary's choice among those health care providers who have been credentialed by the insurer to provide health care services to the beneficiaries of that health benefits plan. Monetary advantage or penalty includes, but is not limited to, a higher copayment, a reduction in reimbursement for services, or any other promotion of one health care provider over another health care provider.

SECTION 6.

(a) If a health care provider fails to meet the terms and conditions, the utilization regulations, or the quality standards established by the insurer under a health benefits plan, the insurer may refuse to renew the credentials of that health care provider or may take steps to revoke the credentials of that health care provider.

(b) When an insurer denies credentials to a health care provider or refuses to renew or takes steps to revoke the credentials of a health care provider, the insurer shall inform the health care provider in writing of the reasons for its decision and shall comply with all the other requirements of this section. An insurer shall not terminate a health care provider from providing health care services under a health benefits plan without cause.

(c) Prior to making a decision to revoke or not to renew that credentials of a health care provider, an insurer shall inform the health care provider of the concerns it has regarding that provider, shall afford an opportunity for discussion of these concerns, and shall offer to develop a corrective action plan to address these concerns, except in

cases where the insurer believes the health care provider is causing imminent harm to patients' health.

(d) The insurer shall establish an appeal mechanism through which a health care provider may challenge the insurer's decision to deny credentials to a provider or to refuse to renew or to revoke the provider's credentials. This appeal mechanism shall incorporate the procedural protections set forth in the Health Care Quality Improvement Act of 1986, Title 42, United States Code, Section 11112, and shall include all the following elements:

(1) The insurer may refuse to renew or may revoke the credentials of a health care provider only after the insurer has made a reasonable effort to obtain all the facts and only after the insurer has made a determination that the health care provider does not meet the terms and conditions, the utilization regulations, or the quality standards of the health benefits plan.

(2) Prior to taking such action, the insurer shall provide written notice to the health care provider stating:

(A) That such action is proposed to be taken;

(B) The reasons for the proposed action;

(C) That the health care provider has the right to request a hearing on the proposed action;

(D) The time within which the health care provider must request such a hearing (which time shall be at least thirty (30) days); and

(E) A summary of the hearing rights of the health care provider as set forth in this subsection.

(3) If the health care provider timely requests a hearing, the insurer shall give the health care provider a notice stating the date, time, and place of the hearing (which date shall be at least thirty (30) days after the date of the notice)

and a list of the witnesses, if any, expected to testify at the hearing on behalf of the insurer.

(4) The hearing shall be conducted by an arbitrator mutually agreed to by the insurer and the health care provider or by a hearing officer or panel of individuals appointed by the insurer who are not in direct economic competition with the health care provider who requested the hearing. At the hearing the health care provider has the right:

(A) To be represented by an attorney or other person of his, her or its choice;

(B) To have a record made of the proceedings and to obtain a copy of the record upon payment of a reasonable charge;

(C) To call, examine, and cross-examine all witnesses;

(D) To present evidence determined by the person(s) conducting the hearing to be relevant, regardless of its admissibility in a court of law; and

(E) To submit a written statement at the close of the hearing and to have a reasonable time (at least ten (10) days) after the conclusion of the hearing to prepare this written statement.

(5) The health care provider shall have the right to receive both the written recommendation of the person(s) conducting the hearing, including a statement of the basis of the recommendation, and the written decision of the insurer, including a statement of the basis of the decision.

(6) When the health care provider has initiated an appeal as provided in this section, unless the insurer finds that the health care provider is causing imminent harm to patients' health, the health care provider's credentials shall remain effective until the insurer has rendered its final decision on the appeal.

(7) After the insurer has made its final decision on an appeal by a health care provider, if the decision is adverse to the health care provider, the health care provider may exercise the right of judicial review provided by Section 8, but may not re-apply to the insurer for new credentials for a period of at least two (2) years from the date of the final decision by the insurer.

(e) The provisions of subsection (d) shall also be available to a health care provider who has been refused credentials because the insurer determined that the provider has a history of unprofessional conduct or a pattern of malpractice.

SECTION 7.

(a) Nothing in this act shall prevent an insurer from instituting measures to maintain quality and to control costs, including but not limited to the utilization of a gatekeeper system, so long as such measures are not inconsistent with the provisions of this act.

(b) An insurer which provides coverage in a health benefits plan for dental services, eye and/or vision care services, or obstetrical/gynecological services shall not require a beneficiary to seek approval from a gatekeeper or from any other person before choosing, from the list of health care providers credentialed under the health benefits plan, a health care provider to provide such covered services to the beneficiary. If a health benefits plan provides coverage for dental, eye and/or vision care services, any health care provider properly licensed under Title 63, Chapters 5, 6, 8, or 9 and credentialed by the insurer under that health benefits plan, may be selected by a beneficiary to provide to that beneficiary the full range of dental, eye and/or vision care services within the scope of the provider’s license.

SECTION 8.

(a) A health care provider or a beneficiary of a health benefits plan who is adversely affected by a violation of this act shall have the right to bring a civil action in a

court of competent jurisdiction for injunctive relief against an insurer which has violated any provision of this act. In addition to injunctive relief, the court shall allow a prevailing plaintiff to recover the plaintiff's actual damages or the sum of one thousand dollars ($1,000), whichever is greater, as well as attorney's fees and costs.

(b) A health care provider who is aggrieved by a final decision of an insurer to revoke or not to renew the provider's credentials shall have the right to appeal that decision to the Chancery Court of the county in which the health care provider has his, her, or its primary office. The court's review shall be a de novo review of the record made before the person(s) conducting the hearing provided by the insurer.

SECTION 9. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 10. This act shall take effect January 1, 1998, the public welfare requiring it.

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